Selección de Resúmenes de Menopausia

Semana del 15 al 21 de Marzo de 2017

Juan Enrique Blümel. Departamento Medicina Sur. Universidad de Chile

J Am Geriatr Soc. 2017 Mar;65(3):490-495. doi: 10.1111/jgs.14668. Epub 2016 Nov 7.

Osteoporosis Treatment Efficacy for Men: A Systematic Review and Meta-Analysis.

Nayak S, Greenspan SL.

OBJECTIVES: To evaluate the efficacy of treatment options to reduce osteoporotic fracture risk in men. DESIGN: Systematic review and meta-analysis. SETTING: Randomized clinical trials that evaluated the efficacy of a treatment for osteoporosis or low bone mineral density for adult men and reported fracture outcomes. PARTICIPANTS: Men. MEASUREMENTS: PubMed, Embase, and the Cochrane Library databases were searched for relevant studies. Information was extracted from included studies on participant sociodemographic characteristics, number of male participants, treatment evaluated, comparator for evaluated treatment, study duration, and fracture outcomes. Risk of bias of individual studies was assessed using measures recommended by the Cochrane Collaboration. RESULTS: Twenty-four articles reporting results for 22 studies (including 4,868 male participants) met strict inclusion criteria. Fixed-effects meta-analyses using the Mantel-Haenszel method demonstrated significantly lower risk of vertebral fractures with alendronate (relative risk (RR) = 0.328, 95% confidence interval (CI) = 0.155-0.692) and risedronate (RR = 0.428, 95% CI = 0.245-0.746) but not with calcitonin (RR = 0.272, 95% CI = 0.046-1.608) or denosumab (RR = 0.256, 95% CI = 0.029-2.238) than in controls. For bisphosphonates as a treatment category, meta-analyses demonstrated significantly lower risk of vertebral fractures (RR = 0.368, 95% CI = 0.252-0.537) and nonvertebral fractures (RR = 0.604, 95% CI = 0.404-0.904) than in controls. The meta-analysis finding that bisphosphonates significantly reduce nonvertebral fracture risk was not robust to sensitivity analysis. CONCLUSION: Bisphosphonates reduce the risk of vertebral and possibly nonvertebral fractures for men with osteoporosis. Further studies are needed to evaluate the efficacy of bisphosphonates for reducing nonvertebral fracture risk and the efficacy of nonbisphosphonates for reducing vertebral and nonvertebral fracture risk in men with osteoporosis.

Curr Med Res Opin. 2017 Mar 17:1-19. doi: 10.1080/03007995.2017.1308343. [Epub ahead of print]

Can osteoporosis increase the incidence of heart failure in adults?

Chiu CZ, Yeh JH, Shyu KG, Hou SM, Lin CL, Liang JA.

BACKGROUNDS: Recent studies have suggested shared comorbidities between heart failure and osteoporosis. In addition, patients with osteoporosis are associated with increased risks of developing cardiovascular disease. METHODS: A retrospective cohort analysis was conducted to determine the association between osteoporosis and heart failure. Data were from the Longitudinal Health Insurance Database 2000 (LHID2000), Taiwan. Patients with newly diagnosed osteoporosis were identified, and osteoporosis-free controls were randomly selected from the general population and frequency-matched according to age, sex, and index year by using the LHID2000. We analyzed the risks of heart failure using Cox proportional-hazards regression models. RESULTS: During the mean follow-up of 7.1 ± 3.5 years, the cumulative incidence of heart failure was 2.24% higher in the osteoporosis cohort than in the comparison cohort ($P < 0.001$). The overall incidence of heart failure was 10.3 versus 7.62 per 1,000 person-years in the osteoporosis patients and the controls, respectively, with an adjusted HR of 1.13 (95% CI = 1-06-1.21). CONCLUSION: We observed a higher incidence to develop heart failure in Taiwanese adults with osteoporosis, especially in those with chronic comorbidities. There might be linking pathophysiology and mechanisms from osteoporosis to heart failure.

Australas J Ageing. 2017 Mar;36 Suppl 1:8-13. doi: 10.1111/ajag.12408.

Vitamin D, bones and muscle: myth versus reality.

Duque G, Daly RM, Sanders K, Kiel DP.

OBJECTIVES: Evidence regarding the efficacy and dosing of vitamin D on fall and fracture prevention, with or without calcium, is characterised by uncertainty. METHODS: A panel of experts was organised at the First Australasian Conference on Sarcopenia and Frailty in Melbourne, Australia, in November 2016 to provide an

interpretation of the current evidence and to give their opinions regarding the supplementation of vitamin D in three hypothetical cases. RESULTS AND CONCLUSION: The authors conclude that (i) target serum 25(OH)D concentration should be 50 to 60 nmol/L year round, with a conservative upper limit <100 nmol/L; (ii) change in serum concentrations at any given dose is highly variable among individuals; (iii) dosing interval may need to be <2 months to have a continuous benefit; (iv) a loading dose can raise levels to target quickly, but there is no evidence yet that this has any positive effect on falls or fracture outcomes; and (v) a maintenance dose of 1000 IU/day, or given as an equivalent dose weekly or monthly, is sufficient for most individuals.

Int Urogynecol J. 2017 Mar 14. doi: 10.1007/s00192-017-3295-6. [Epub ahead of print]

Deconstructing the genitourinary syndrome of menopause.

Vieira-Baptista P, Marchitelli C, Haefner HK, Donders G, Pérez-López F.

The concept of genitourinary syndrome of menopause (GSM) was recently introduced and has been gaining widespread use. While some justifications for its introduction are straightforward, others may be questionable. Numerous unspecific symptoms and signs were included in the definition of the syndrome, but the minimum number required for diagnosis was not established. While the GSM definition is designed to facilitate identifying vulvovaginal and urinary estrogen-deprivation-associated symptoms and signs, several concerns have evolved: (1) the syndrome may result in the underdiagnosis of vulvar and urinary pathology; and (2) serious conditions (e.g., high-grade squamous intraepithelial lesions of the vulva or vulvar intraepithelial neoplasia, differentiated type) may be missed while others may not receive appropriate treatment (e.g., lichen sclerosus, overactive bladder). In addition, the transformation of urogenital symptoms and signs into a syndrome may create an iatrogenization of menopause, which, consequently, can lead to demand for (and offer of) a panacea of treatments. This can be detrimental to the care of women who require focused therapy rather than global treatment addressing a variety of genitourinary conditions, not all of which even require any form of intervention. Women's needs may be better served by having a more precise urogenital diagnosis.

Menopause. 2017 Mar 13. doi: 10.1097/GME.0000000000000863. [Epub ahead of print]

A sex-specific dose-response curve for testosterone: could excessive testosterone limit sexual interaction in women?

Krapf JM, Simon JA.

Testosterone treatment increases sexual desire and well-being in women with hypoactive sexual desire disorder; however, many studies have shown only modest benefits limited to moderate doses. Unlike men, available data indicate women show a bell-shaped dose-response curve for testosterone, wherein a threshold dosage of testosterone leads to desirable sexual function effects, but exceeding this threshold results in a lack of further positive sexual effects or may have a negative impact. Emotional and physical side-effects of excess testosterone, including aggression and virilization, may counteract the modest benefits on sexual interaction, providing a possible explanation for a threshold dose of testosterone in women. In this commentary, we will review and critically analyze data supporting a curvilinear dose-response relationship between testosterone treatment and sexual activity in women with low libido, and also explore possible explanations for this observed relationship. Understanding optimal dosing of testosterone unique to women may bring us one step closer to overcoming regulatory barriers in treating female sexual dysfunction.

Climacteric. 2017 Apr;20(2):119-124. doi: 10.1080/13697137.2017.1286890. Epub 2017 Feb 8.

Exercise and nutritional approaches to prevent frail bones, falls and fractures: an update.

Daly RM.

Osteoporosis (low bone strength) and sarcopenia (low muscle mass, strength and/or impaired function) often co-exist (hence the term 'sarco-osteoporosis') and have similar health consequences with regard to disability, falls, frailty and fractures. Exercise and adequate nutrition, particularly with regard to vitamin D, calcium and protein, are key lifestyle approaches that can simultaneously optimize bone, muscle and functional outcomes in older people, if they are individually tailored and appropriately prescribed in terms of the type and dose. Not all forms of exercise are equally effective for optimizing musculoskeletal health. Regular walking alone has little or no effect on bone or muscle. Traditional progressive resistance training (PRT) is effective for improving muscle mass, size and strength, but it has mixed effects on muscle function and falls which may be due to the common prescription of slow and controlled

movement patterns. At present, targeted multi-modal programs incorporating traditional and high-velocity PRT, weight-bearing impact exercises and challenging balance/mobility activities appear to be most effective for optimizing musculoskeletal health and function. Reducing and breaking up sitting time may also help attenuate muscle loss. There is also evidence to support an interaction between exercise and various nutritional factors, particularly protein and some multi-nutrient supplements, on muscle and bone health in the elderly. This review summary provides an overview of the latest evidence with regard to the optimal type and dose of exercise and the role of various nutritional factors for preventing bone and muscle loss and improving functional capacity in older people.

Climacteric. 2017 Apr;20(2):157-163. doi: 10.1080/13697137.2017.1282452. Epub 2017 Feb 8.

Age-related prevalence of osteoporosis and fragility fractures: real-world data from an Austrian Menopause and Osteoporosis Clinic.

Boschitsch EP, Durchschlag E, Dimai HP.

Age and bone mineral density (BMD) are the most relevant determinants for public health authorities to govern the management of osteoporosis. The objectives of this study were to determine the age-related prevalence of osteopenia and osteoporosis according to WHO criteria and fragility fractures in middle-aged and older women. METHODS: Women ≥40 years, who were referred to a menopause and osteoporosis outpatient clinic for BMD measurements, were assessed for patient characteristics, BMD and previous fragility fractures of the hip, the distal forearm and the vertebrae. Only records of their initial consultations were used for data analysis. RESULTS: Between 1990 and 2012, 99,399 women, mean age 56.1 years, were referred to the clinic for BMD testing. Of the total population, 52.5% showed normal, 34.0% osteopenic and 13.5% osteoporotic BMD. Fragility fractures were reported by 6540 patients, with 3070 (47%) non-vertebral fractures, namely 2518 (38.5%) distal forearm and 552 (8.4%) hip fractures; 66.8% of patients with the non-vertebral fractures were <65 years. CONCLUSION: The prevalence of osteoporosis and fragility fractures in middle-aged women, < 65 years, is hitherto under-recognized. Measuring BMD alone is not sufficient to identify patients at risk for fractures. Supplemental screening for clinical risk factors already during perimenopause may be advantageous.

Climacteric. 2017 Apr;20(2):91-96. doi: 10.1080/13697137.2017.1280251. Epub 2017 Mar 10.

The evidence base for HRT: what can we believe?

Langer RD.

Prior to the unexpected early termination of the Women's Health Initiative (WHI) trial of continuous conjugated equine estrogens (CEE) and medroxyprogesterone acetate (MPA), the prevailing view was that hormone replacement therapy (HRT) was a low-risk intervention with immediate value for symptom relief in recently menopausal women, and that it probably conferred long-term protection against the major chronic diseases that affect women after menopause. Rather than replicating prior studies, the WHI was designed to test whether the beneficial associations consistently seen in women starting HRT near menopause would be found in women well beyond menopause. Views of the benefits and risks of HRT changed dramatically in 2002 with the unexpected early termination of the CEE + MPA trial and the alarming initial WHI report. HRT use plummeted world-wide, driven by fear of breast cancer and skepticism about cardiovascular benefits. Stunningly, the contrasting findings of the WHI trial of CEE alone reported 2 years later - suggesting prevention of coronary heart disease in women who began HRT at age <60 years, and a reduction in breast cancer overall - were largely ignored. Key lessons from the WHI are that the effects of HRT on most organ systems vary by age and time since last physiologic exposure to hormones and that there are differences between regimens. In the years since the first WHI report, we have learned much about the characteristics of women who are likely to benefit from HRT. The range of HRT regimens has also increased. Not all women have indications for HRT, but for those who do and who initiate within 10 years of menopause, benefits are both short-term (vasomotor, dyspareunia), and long-term (bone health, coronary risk reduction). Critically, the 'facts' that most women and clinicians consider in making the decision to use, or not use, HRT are frequently wrong or incorrectly applied.